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## **1.0 Description of the Procedure, Product, or Service**

Special ophthalmological services are special evaluations of part of the visual system, which go beyond the services included under general ophthalmological services or in which special treatment is given. Interpretation and report by the physician is an integral part of special ophthalmological services where indicated.

Special ophthalmological services include the following procedures:

### **1.1 Computerized Corneal Topography**

Computerized corneal topography describes measurement of the curvature of the cornea. An evaluation of corneal topography is necessary for the accurate diagnosis and follow-up of certain corneal disorders. The topology of the cornea is analyzed by computer software, and reports are produced for physician evaluation.

### **1.2 Sensorimotor Examination**

A sensorimotor examination is an evaluation of the function of the ocular muscle system. Vertical and horizontal prism bars or individual handheld prisms are used to measure ocular deviation. The exam may include qualitative and quantitative testing of ocular motility, accommodation and binocular function.

### **1.3 Fitting of Contact Lens for Treatment of Disease**

The primary purpose of fitting of contact lens for treatment of disease is to promote healing, decrease pain, aid in therapeutic drug delivery and help maintain ocular surface hydration. The contact lens is part of the rehabilitative process or treatment plan. The intention of the contact lens in such a case is not for visual function.

### **1.4 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)**

The two forms of scanning computerized ophthalmic diagnostic imaging (SCODI) are confocal scanning laser ophthalmoscopy and scanning laser polarimetry. Confocal scanning laser ophthalmoscopy (topography) uses stereoscopic videographic digitized images to make quantitative topographic measurements of the optic nerve head and surrounding retina. Scanning laser polarimetry measures change in the linear polarization of light (retardation). It uses both a polarimeter (an optical device to measure linear polarization change) and a scanning laser ophthalmoscope, to measure the thickness of the nerve fiber layer of the retina. Although these techniques differ, the objective is the same, to provide more precise methods of observation of the optic nerve head and more accurately reveal subtle glaucomatous changes over the course of time than visual fields and disc photos. These testing devices use videographic digitized images to make quantitative topographic measurements of the optic nerve head and surrounding retina to allow for early detection of glaucoma and more sophisticated analysis for ongoing management.

Posterior segment SCODI allows for detection of optic nerve and retinal nerve fiber layer pathologic changes before there is visual field loss. Anterior segment SCODI is used to examine the anterior segment ocular structures of the eye for evaluation of narrow angle, suspected narrow angle, and mixed narrow and open angle glaucoma. Glaucoma causes many related eye and vision changes, including erosion of the optic nerve and the associated retinal nerve fibers, and loss of peripheral vision. A diagnosis of glaucoma usually relies on the analysis of all available clinical data. When these tests are appropriately used in the management of glaucoma or glaucoma suspect, therapy can be initiated before there is irreversible loss of vision.

### **1.5 Ophthalmic Biometry**

Ophthalmic Biometry (Optical Coherence Biometry - OCB) is an ophthalmic diagnostic test which utilizes a non-invasive, non-contact device to measure the corneal curvature, anterior chamber depth and axial length of the eye without ultrasound. The measurements are stored in a computer and automatically transferred to the intraocular lens (IOL) calculator program, allowing immediate and individualized computation of IOL implant options.

### **1.6 Fundus Photography**

Retinal eye screening via fundus photography provides early detection of retinopathy in diabetes patients. Because diabetic retinopathy is often asymptomatic, its presence can be noted only through direct evaluation of the retina. Fundus photographs allow a complete view of the posterior segment of the inner aspect of the eye to document alterations in the optic nerve head, retinal vessels and retinal epithelium. These photographs can be used to document base line retinal findings or track disease progression to prevent or decrease blindness due to diabetic retinopathy.

### **1.7 Electrophysiologic Retinal Testing**

Electrophysiologic retinal testing is done to diagnose specific disorders of the retina. The most commonly performed electrophysiologic test is the electroretinogram (ERG). Other electrophysiologic tests include electro-oculography (EOG), dark adaptometry, and special color vision testing.

The ERG measures the electrical response of the retina to flashes of light. The EOG measures the difference in the electrical potential between the front and back of the eye in response to dark and light. Dark adaptometry measures the period of time which passes before the retina regains its maximal sensitivity to low amounts of light when going from conditions of bright light to darkness.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
None Apply.

### 2.2 Special Provisions

#### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service

requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*  
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://dma.ncdhhs.gov/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

### **3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

#### **3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

#### **3.2 Specific Criteria Covered**

##### **3.2.1 Specific criteria covered by both Medicaid and NCHC**

Although technical procedures are part of Special Ophthalmological Services, they do not constitute the complete service, an interpretation and report by the rendering provider is an integral part of the service and must be completed for each test provided. This report must address the findings, relevant clinical issues, and comparative data.

##### **3.2.2 Computerized Corneal Topography**

Computerized corneal topography is indicated in the identification of deep or superficial corneal disorders causing irregular astigmatism and visual impairment.

Medicaid and NCHC shall cover computerized corneal topography when it is determined to be medically necessary, the beneficiary meets any of the following indications below and the results will assist in defining further treatment:

- a. pre-operative evaluation of irregular astigmatism for intraocular lens power determination with cataract surgery;
- b. monocular diplopia;
- c. diagnosis of keratoconus;
- d. post-surgical or post-traumatic astigmatism, measuring at a minimum of 3.5 diopters;
- e. suspected irregular astigmatism based on retinoscopic streak or conventional keratometry;
- f. post-penetrating keratoplasty surgery;
- g. post-surgical or post-traumatic irregular astigmatism;
- h. corneal dystrophies;
- i. complications of transplanted cornea;
- j. post-traumatic corneal scarring; **or**

- k. pterygium or corneal ectasia that cause visual impairment.

### **3.2.3 Sensorimotor Examination**

Sensorimotor examination requires the assessment of both eyes. It includes ocular alignment measurements in more than one field of gaze and inclusion of at least one appropriate sensory test in beneficiaries who are able to respond. Examples of sensory function testing include Worth 4 dot, Maddox rod, and Bagolini lenses.

Medicaid and NCHC shall cover sensorimotor examination when considered medically necessary for any of the following conditions:

- a. diplopia;
- b. exotropia;
- c. esotropia;
- d. hypertropia; or
- e. paralytic strabismus.

### **3.2.4 Fitting of Contact Lens**

- a. Medicaid and NCHC shall cover the fitting of contact lens for the treatment of disease for any of the following conditions:
  - 1. bullous keratopathy;
  - 2. dry eyes;
  - 3. corneal ulcers;
  - 4. corneal abrasions;
  - 5. keratitis;
  - 6. corneal edema;
  - 7. desce-metocoele;
  - 8. corneal ectasis;
  - 9. Mooren's ulcer;
  - 10. anterior corneal dystrophy; or
  - 11. neurotrophic keratoconjunctivitis.
- b. The initial fitting of gas permeable contact lens is indicated for the management of keratoconus.

### **3.2.5 Scanning Computerized Ophthalmic Diagnostic Imaging**

Medicaid and NCHC shall cover SCODI to diagnose early glaucoma and monitor glaucoma treatment in beneficiaries with mild to moderate damage.

Glaucomatous damage is defined by one of the following criteria:

- a. glaucoma-suspect or mild glaucomatous damage (mild stage glaucoma):
  - 1. anomalous appearing optic nerve;
  - 2. intraocular pressure greater than 22 mmHg as measured by applanation;
  - 3. symmetric or vertically elongated cup enlargement, neural rim intact, cup to disc ratio greater than 4.0;
  - 4. focal optic disk notch;
  - 5. optic disk hemorrhage or history of optic disk hemorrhage;
  - 6. nasal step or small paracentral or arcuate scotoma; **or**
  - 7. mild constriction of visual field isopters



- b. moderate glaucomatous damage\_(moderate stage glaucoma):
  - 1. enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio greater than 0.5, but less than 0.9;
  - 2. definite focal notch with thinning of the neural rim; **or**
  - 3. definite glaucomatous visual field defect, e.g., arcuate or paracentral scotoma, nasal step, pencil wedge, or constriction of isopters.
- c. advanced glaucomatous damage\_(severe stage glaucoma):
  - 1. severe generalized constriction of isopters (i.e., Goldmann 14e greater than 10 degrees of fixation);
  - 2. absolute visual field defects within 10 degrees of fixation;
  - 3. severe generalized reduction of retinal sensitivity;
  - 4. loss of central visual acuity, with temporal island remaining;
  - 5. diffuse enlargement of optic nerve cup, with cup to disc ratio greater than 0.8; **or**
  - 6. wipe-out of all or a portion of the neural retinal rim.

### **3.2.6 Ophthalmic Biometry**

Medicaid and NCHC shall cover the performance of Ophthalmic Biometry (Optical Coherence Biometry - OCB) when considered medically necessary and performed preoperatively for the purpose of determining intraocular lens power in a beneficiary undergoing cataract surgery. The provider who is performing the cataract surgery shall perform the OCB.

### **3.2.7 Fundus Photography**

Medicaid and NCHC shall cover fundus photography for examination of the retina to document disease process, plan treatment or follow the progress of diabetic retinopathy in beneficiaries with diabetes.

### **3.2.8 Electrophysiologic Retinal Testing**

Medicaid and NCHC shall cover electrophysiologic retinal testing when it is determined to be medically necessary, and the beneficiary meets any of the following indications below:

- a. confirmation of neurologic or ophthalmologic disease;
- b. unexplained visual loss;
- c. family history of poor vision;
- d. inherited visual disorders; or
- e. assessment of optic nerve function following trauma.

### **3.2.9 Medicaid Additional Criteria Covered**

None Apply.

### **3.2.10 NCHC Additional Criteria Covered**

For NCHC beneficiaries, age-appropriate modifications may be required at the discretion of the provider.

## 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Criteria Not Covered

#### 4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover special ophthalmological services when the criteria in **Subsection 3.2** are not met.

#### 4.2.2 Computerized Corneal Topography

Medicaid and NCHC shall not cover computerized corneal topography for any of the following:

- a. routine follow-up testing;
- b. repeat testing if not indicated by a change of vision as reported in connection with one of the listed conditions in **Subsection 3.2.2**;
- c. on the same date of service as keratoplasty; or
- d. services performed for screening purposes.

#### 4.2.3 Scanning Computerized Ophthalmic Diagnostic Imaging

Medicaid and NCHC shall not cover SCODI for the following:

- a. to further validate a diagnosis that has been confirmed through earlier detection;
- b. for beneficiaries with advanced glaucomatous damage; instead, visual fields must be performed;
- c. when performed in the absence of an indication as denoted by one of the diagnoses listed in **Attachment A, B**;
- d. when performed as screening; or
- e. SCODI of the optic nerve and SCODI of the retina are not covered on the same date of service.

#### 4.2.4 Ophthalmic biometry

Medicaid and NCHC shall not cover ophthalmic biometry (Optical Coherence Biometry - OCB) by partial coherence interferometry on the same date of service as ophthalmic biometry by ultrasound echography, A-scan.

#### **4.2.5 Fundus Photography**

Medicaid and NCHC shall not cover fundus photography for any of the following:

- a. to screen or evaluate retinal conditions other than diabetic retinopathy;
- b. when the final composite image captured does not include the entire Diabetic Retinopathy Study seven-standard field area ( DRS 7); or
- c. when the final retinal images are graded using an automatic process only.

#### **4.2.6 Medicaid Additional Criteria Not Covered**

None Apply.

#### **4.2.7 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

### **5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

#### **5.1 Prior Approval**

Medicaid and NCHC shall not require prior approval for Special Ophthalmological Services

#### **5.2 Prior Approval Requirements**

##### **5.2.1 General**

None Apply

##### **5.2.2 Specific**

None Apply.

#### **5.3 Documentation Requirements**

Although health records are not required to be submitted for payment of Special Ophthalmological Services, the records must be available upon request by DMA. Documentation must include all of the following:

- a. medical history;
- b. ophthalmologic examination findings;
- c. results of diagnostic tests or procedures; and
- d. when applicable, photographs including written interpretations.

## **5.4 Limitations**

### **5.4.1 Separate Procedures**

Special Ophthalmological Services include procedures and services that are designated as separate procedures. A separate procedure is one that is carried out as an integral component of a total service or procedure. The services or procedures designated as separate procedures must not be billed in addition to the total procedure or service of which it is considered an integral component. These services or procedures must be reported only when performed independently, unrelated or distinct from other procedures or services provided.

### **5.4.2 Fitting of contact lens for treatment of disease and for management of keratoconus**

Fitting of contact lens for treatment of disease is limited to four lenses per 365 days.

### **5.4.3 Scanning Computerized Ophthalmic Diagnostic Imaging**

- a. Pre-glaucoma beneficiaries or those with mild damage as describe in **Subsection 3.2.5.a** may receive one SCODI per 365 days.
- b. Beneficiaries with moderate damage as described in **Subsection 3.2.5.b.** may receive up to two SCODIs per 365 days OR one SCODI and one visual field per 365 days if medically necessary. When both tests are performed, only one of each test is covered per 365 days.

### **5.4.4 Fundus Photography**

Fundus photography studies are limited to one per 365 days for detection and interpretation of diabetic retinopathy in beneficiaries with a diagnosis of diabetes mellitus.

## **6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

None Apply.

### **6.2 Provider Certifications**

None Apply.

## 7.0 Additional Requirements

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 7.1 Compliance

- Provider(s) shall comply with the following in effect at the time the service is rendered:
- All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
  - All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

## 8.0 Policy Implementation/Revision Information

**Effective Date:** January 1, 1999

### Revision Information:

| Date       | Section Revised                | Change   |
|------------|--------------------------------|--|
| 09/01/2004 | Section 5.0                    | Added medical necessity criteria and limitations relative to visual fields   |
| 09/01/2005 | Section 2.0                    | A special provision related to EPSDT was added.  |
| 12/01/2005 | Subsection 2.2                 | The web address for DMA's EDPST policy instructions was added to this section.   |
| 12/01/2006 | Sections 2 through 5           | A special provision related to EPSDT was added.  |
| 05/01/2007 | Sections 2 through 5           | EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age   |
| 07/01/2010 | All sections and attachment(s) | Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services. |
| 01/15/2013 | All sections and attachment(s) | To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1T-2 under Session Law 2011-145 § 10.41.  |
| 01/15/2013 | All sections and attachment(s) | Deleted references to scanning laser glaucoma tests (SLGT).  |
| 01/15/2013 | All sections and attachment(s) | Title of policy changed from Scanning Laser Glaucoma Tests to Special Ophthalmological Services.   |
| 01/15/2013 | All sections and attachment(s) | Technical changes to merge Medicaid and NCHC current coverage into one policy.   |
| 01/15/2013 | Section 1.0                    | Added description of Special Ophthalmological Services.  |
| 01/15/2013 | Subsections 1.1 through 1.7    | Included procedure descriptions.   |
| 01/15/2013 | Subsection 3.2                 | Added this section   |

| <b>Date</b> | <b>Section Revised</b>         | <b>Change</b>  |
|-------------|--------------------------------|--|
| 01/15/2013  | Subsection 3.2.3               | Added Medicaid covers fitting of gas permeable contact lens for the treatment of keratoconus initial                                 |
| 01/15/2013  | Subsection 3.2.4 a             | Added mild stage glaucoma  |
| 01/15/2013  | Subsection 3.2.4 b             | Added moderate stage glaucoma  |
| 01/15/2013  | Subsection 3.2.4 c             | Added severe stage glaucoma  |
| 01/15/2013  | Subsection 4.2                 | Added specific non-coverage criteria   |
| 01/15/2013  | Subsection 5.1                 | Added statement regarding no requirement for prior approval  |
| 01/15/2013  | Subsection 5.2                 | Added documentation requirements.  |
| 01/15/2013  | Subsection 5.3                 | Added limitations for special ophthalmological services procedures   |
| 01/15/2013  | Subsection 5.3.4 b.            | Removed remote site imaging for monitoring of active retinal disease   |
| 01/15/2013  | Subsection 5.3.3c              | Removed remote site imaging for monitoring of active retinal disease   |
| 01/15/2013  | Subsection 5.3.4b              | Removed remote site imaging for monitoring of active retinal disease   |
| 01/15/2013  | Subsection 8.0                 | Moved to Attachment A: Claims Related Information  |
| 01/15/2013  | Subsection 9.0                 | Moved to Section 8.0   |
| 01/15/2013  | Attachment A, B                | Added description of diagnosis codes that support medical necessity for SCODI and fundus photography                                 |
| 01/15/2013  | All sections and attachment(s) | Replaced “recipient” with “beneficiary.”   |
| 10/01/2015  | All Sections and Attachments   | Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable. |
| 08/01/2017  | Attachment A<br>Section B      | Deleted ICD 10 codes that were end-dated and replaced with appropriate ICD 10 codes.   |
| 11/01/2017  | Attachment A<br>Section B      | 2017 ICD 10 diagnosis codes were added under Fundus Photography.   |

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

### A. Claim Type

Professional (CMS-1500/837P transaction)

### B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Claims must contain one of the following diagnosis codes to support medical necessity for SCODI procedures:

| ICD-10-CM Code(s)      |          |          |
|------------------------|----------|----------|
| Service Provided SCODI |          |          |
| H21.231                | H40.1394 | H40.41x4 |
| H21.232                | H40.1410 | H40.42x0 |
| H21.233                | H40.141  | H40.42x1 |
| H21.239                | H40.142  | H40.42x2 |
| H21.40                 | H40.143  | H40.42x3 |
| H21.41                 | H40.1494 | H40.42x4 |
| H21.42                 | H40.1510 | H40.43x0 |
| H21.43                 | H40.1511 | H40.43x1 |
| H21.521                | H40.1512 | H40.43x2 |
| H21.522                | H40.1513 | H40.43x3 |
| H21.523                | H40.1514 | H40.43x4 |
| H21.529                | H40.1520 | H40.50x0 |
| H21.551                | H40.1521 | H40.50x1 |
| H21.552                | H40.1522 | H40.50x2 |
| H21.553                | H40.1523 | H40.50x3 |
| H21.559                | H40.1524 | H40.50x4 |
| H35.451                | H40.1530 | H40.51x0 |
| H35.452                | H40.1531 | H40.51x1 |
| H35.453                | H40.1532 | H40.51x2 |
| H35.459                | H40.1533 | H40.51x3 |
| H35.89                 | H40.1534 | H40.51x4 |
| H36                    | H40.1590 | H40.52x0 |
| H40.001                | H40.1591 | H40.52x1 |
| H40.002                | H40.1592 | H40.52x2 |
| H40.003                | H40.1593 | H40.52x3 |
| H40.009                | H40.1594 | H40.52x4 |

|          |          |          |
|----------|----------|----------|
| H40.011  | H40.20x0 | H40.53x0 |
| H40.012  | H40.20x1 | H40.53x1 |
| H40.013  | H40.20x2 | H40.53x2 |
| H40.019  | H40.20x3 | H40.53x3 |
| H40.031  | H40.20x4 | H40.53x4 |
| H40.032  | H40.211  | H40.60x0 |
| H40.033  | H40.212  | H40.60x1 |
| H40.039  | H40.213  | H40.60x2 |
| H40.041  | H40.219  | H40.60x3 |
| H40.042  | H40.2210 | H40.60x4 |
| H40.043  | H40.2211 | H40.61x0 |
| H40.049  | H40.2212 | H40.61x1 |
| H40.051  | H40.2213 | H40.61x2 |
| H40.052  | H40.2214 | H40.61x3 |
| H40.053  | H40.2220 | H40.61x4 |
| H40.059  | H40.2221 | H40.62x0 |
| H40.10x0 | H40.2222 | H40.62x1 |
| H40.10x1 | H40.2223 | H40.62x2 |
| H40.10x2 | H40.2224 | H40.62x3 |
| H40.10x3 | H40.2230 | H40.62x4 |
| H40.10x4 | H40.2231 | H40.63x0 |
| H40.1110 | H40.2232 | H40.63x1 |
| H40.1111 | H40.2233 | H40.63x2 |
| H40.1112 | H40.2234 | H40.63x3 |
| H40.1113 | H40.2290 | H40.63x4 |
| H40.1114 | H40.2291 | H40.811  |
| H40.1120 | H40.2292 | H40.812  |
| H40.1121 | H40.2293 | H40.813  |
| H40.1122 | H40.2294 | H40.819  |
| H40.1123 | H40.231  | H40.821  |
| H40.1124 | H40.232  | H40.822  |
| H40.1130 | H40.233  | H40.823  |
| H40.1131 | H40.239  | H40.829  |
| H40.1132 | H40.241  | H40.831  |
| H40.1133 | H40.242  | H40.832  |
| H40.1134 | H40.243  | H40.833  |
| H40.1210 | H40.249  | H40.839  |
| H40.1211 | H40.30x0 | H40.89   |
| H40.1212 | H40.30x1 | H40.9    |
| H40.1213 | H40.30x2 | H42      |
| H40.1214 | H40.30x3 | H47.10   |
| H40.1220 | H40.30x4 | H47.11   |
| H40.1221 | H40.31x0 | H47.12   |
| H40.1222 | H40.31x1 | H47.143  |
| H40.1223 | H40.31x2 | H47.149  |
| H40.1224 | H40.31x3 | H47.9    |
| H40.1230 | H40.31x4 | H53.40   |
| H40.1231 | H40.32x0 | H53.411  |
| H40.1232 | H40.32x1 | H53.412  |



|          |          |         |
|----------|----------|---------|
| H40.1233 | H40.32x2 | H53.413 |
| H40.1234 | H40.32x3 | H53.419 |
| H40.1290 | H40.32x4 | H53.421 |
| H40.1291 | H40.33x1 | H53.422 |
| H40.1292 | H40.33x2 | H53.423 |
| H40.1293 | H40.33x3 | H53.429 |
| H40.1294 | H40.33x4 | H53.431 |
| H40.1310 | H40.40x0 | H53.432 |
| H40.1311 | H40.40x1 | H53.433 |
| H40.1312 | H40.40x2 | H53.439 |
| H40.1313 | H40.40x3 | H53.451 |
| H40.1314 | H40.40x4 | H53.452 |
| H40.1320 | H40.41x0 | H53.453 |
| H40.1321 | H40.41x1 | H53.459 |
| H40.1322 | H40.41x2 | H53.481 |
| H40.1323 | H40.41x3 | H53.482 |
| H40.1324 |          | H53.483 |
| H40.1330 |          | H53.489 |
| H40.1331 |          | Q15.0   |
| H40.1332 |          |         |
| H40.1333 |          |         |
| H40.1334 |          |         |
| H40.1390 |          |         |
| H40.1391 |          |         |
| H40.1392 |          |         |
| H40.1393 |          |         |

Claims must contain one of the following diagnosis codes to support medical necessity for fundus photography procedures:

| ICD-10-CM Code(s)                   |          |          |
|-------------------------------------|----------|----------|
| Service Provided Fundus Photography |          |          |
| E10.10                              | E11.311  | E13.329  |
| E10.11                              | E11.319  | E13.331  |
| E10.21                              | E11.321  | E13.339  |
| E10.22                              | E11.3211 | E13.341  |
| E10.29                              | E11.3212 | E13.3211 |
| E10.311                             | E11.3213 | E13.3212 |
| E10.319                             | E11.3291 | E13.3213 |
| E10.321                             | E11.3292 | E13.3291 |
| E10.3211                            | E11.3293 | E13.3292 |
| E10.3212                            | E11.3311 | E13.3293 |
| E10.3213                            | E11.3312 | E13.3311 |
| E10.329                             | E11.3313 | E13.3312 |
| E10.3291                            | E11.329  | E13.3313 |
| E10.3292                            | E11.331  | E13.3391 |
| E10.3293                            | E11.339  | E13.3392 |
| E10.331                             | E11.3391 | E13.3393 |

|          |          |          |
|----------|----------|----------|
| E10.3311 | E11.3392 | E13.3411 |
| E10.3312 | E11.3393 | E13.3412 |
| E10.3313 | E11.341  | E13.3413 |
| E10.339  | E11.3411 | E13.349  |
| E10.3391 | E11.3412 | E13.3491 |
| E10.3392 | E11.3413 | E13.3492 |
| E10.3393 | E11.349  | E13.3493 |
| E10.341  | E11.3491 | E13.351  |
| E10.3411 | E11.3492 | E13.3511 |
| E10.3412 | E11.3493 | E13.3512 |
| E10.3413 | E11.351  | E13.3513 |
| E10.349  | E11.3511 | E13.3521 |
| E10.3491 | E11.3512 | E13.3522 |
| E10.3492 | E11.3513 | E13.3523 |
| E10.3493 | E11.3521 | E13.3531 |
| E10.351  | E11.3522 | E13.3532 |
| E10.3511 | E11.3523 | E13.3533 |
| E10.3512 | E11.3531 | E13.3541 |
| E10.3513 | E11.3532 | E13.3542 |
| E10.3521 | E11.3533 | E13.3543 |
| E10.3522 | E11.3541 | E13.3551 |
| E10.3523 | E11.3542 | E13.3552 |
| E10.3531 | E11.3543 | E13.3553 |
| E10.3532 | E13.3551 | E13.359  |
| E10.3533 | E11.3552 | E13.3591 |
| E10.3541 | E11.3553 | E13.3592 |
| E10.3542 | E11.359  | E13.3593 |
| E10.3543 | E11.3591 | E13.36   |
| E10.3551 | E11.3592 | E13.37X1 |
| E10.3552 | E11.3593 | E13.37X2 |
| E10.3553 | E11.36   | E13.37X3 |
| E10.359  | E11.37X1 | E13.39   |
| E10.3591 | E11.37X2 | E13.40   |
| E10.3592 | E11.37X3 | E13.41   |
| E10.3593 | E11.39   | E13.42   |
| E10.36   | E11.40   | E13.43   |
| E10.37X1 | E11.41   | E13.44   |
| E10.37X2 | E11.42   | E13.49   |
| E10.37X3 | E11.43   | E13.51   |
| E10.39   | E11.44   | E13.52   |
| E10.40   | E11.49   | E13.59   |
| E10.41   | E11.51   | E13.610  |
| E10.42   | E11.52   | E13.618  |
| E10.43   | E11.59   | E13.620  |
| E10.44   | E11.610  | E13.621  |
| E10.49   | E11.618  | E13.622  |
| E10.51   | E11.620  | E13.628  |
| E10.52   | E11.621  | E13.630  |
| E10.59   | E11.622  | E13.638  |

|         |         |         |
|---------|---------|---------|
| E10.610 | E11.628 | E13.641 |
| E10.618 | E11.630 | E13.649 |
| E10.620 | E11.638 | E13.65  |
| E10.621 | E11.641 | E13.69  |
| E10.622 | E11.649 | E13.8   |
| E10.628 | E11.65  | E13.9   |
| E10.630 | E11.69  | O24.410 |
| E10.638 | E11.8   | O24.414 |
| E10.641 | E11.9   | O24.415 |
| E10.649 | E13.00  | O24.419 |
| E10.65  | E13.01  | O24.420 |
| E10.69  | E13.10  | O24.424 |
| E10.8   | E13.11  | O24.425 |
| E10.9   | E13.21  | O24.429 |
| E11.00  | E13.22  | O24.430 |
| E11.01  | E13.29  | O24.434 |
| E111    | E13.311 | O24.435 |
| E1110   | E13.319 | O24.439 |
| E1111   | E13.321 | O24.83  |
| E11.21  |         | O24.911 |
| E11.22  |         | O24.912 |
| E11.29  |         | O24.913 |
|         |         | O24.919 |
|         |         | O24.93  |
|         |         | O99.810 |
|         |         | O99.814 |
|         |         | O99.815 |

### C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

| CPT Code(s) |       |       |
|-------------|-------|-------|
| 92025       | 92133 | 92270 |
| 92060       | 92134 | 92275 |
| 92071       | 92136 | 92283 |
| 92072       | 92250 | 92284 |
| 92132       | 92265 |       |

**Note:** Bilateral means the procedure is expected to be done on both eyes and the payment amount accounts for both eyes. Unilateral means the procedure is for a single eye. Unilateral **or** bilateral indicates that the payment amount is the same regardless if one or both eyes are scanned.

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

**F. Place of Service**

Inpatient, outpatient, office.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://dma.ncdhhs.gov/>.

For NCHC refer to [G.S. 108A-70.21\(d\)](#)

**H. Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://dma.ncdhhs.gov/>